



**VISION INSURANCE**  
 Underwritten by National Guardian Life Insurance Company  
 Administered by:  
 Superior Vision Services  
 11101 White Rock Road, Suite 150  
 Rancho Cordova, CA 95670



## Enrollment / Change Form

Please print and complete all sections.

GROUP/EMPLOYEE INFORMATION    A: Add (enroll)   T: Terminate   C: Change (change of name or coverage)										
Employer Name <b>Carteret County</b>			Group Number <b>31056</b>		Location		Effective Date		Date of Hire	
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name		First Name		M.I.	Date of Birth		Social Security Number	
Home Street Address			City/State/Zip			Home Phone (   )			Work Phone (   )	
Email Address									Cell Phone (   )	

### ELECTION(S)

Employee Only

☐

Employee + Spouse

☐

Employee + Child(ren)

☐

Employee + Family

☐

FAMILY INFORMATION (Only those eligible may be enrolled.)   A: Add (enroll)   T: Terminate   C: Change (change of name or coverage)										
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (spouse)		First Name		M.I.	Date of Birth			
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)		First Name		M.I.	Date of Birth		Child unmarried and full-time student or handicapped? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)		First Name		M.I.	Date of Birth		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)		First Name		M.I.	Date of Birth		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)		First Name		M.I.	Date of Birth		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)		First Name		M.I.	Date of Birth		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)		First Name		M.I.	Date of Birth		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.